**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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|---|---|
| Requestor Name and Address:<br>ABILENE REGIONAL MEDICAL CENTER<br>C/O AHC<br>10002 BATTLEVIEW PARKWAY<br>MANASSAS VA 20109 | MFDR Tracking #: M4-06-4448-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br>Ace American Insurance Co.<br>Box #: 15 | Date of Injury:<br>Employer Name:<br>Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "…a fair and reasonable reimbursement is 75 percent of the billed charges, for this claim, this would be a payment of $11,881.07. However, to date, this claim has only been paid at 5 percent of the billed charges, which was a payment of $900.00; by no means should this payment be considered a fair and reasonable payment. "

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill
3. EOBs
4. Medical Records
5. Total Amount Sought - $10,981.07

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "Copy of check issued to Provider ($300.00)"

**Principal Documentation:**

1. Response Package

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 4/12/2005 | 09701, M, 88053, 01115 | Outpatient Surgery | $10,981.07 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on March 6, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 17, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - M – "THE RECOMMENDED PAYMENTS ABOVE REFLECT A FAIR, REASONABLE AND CONSISTENT METHODOLOGY OF REIMBURSEMEN T PURSUANT TO THE CRITERIA SET FORTH IN" [sic]
   - 09701 – no explanation of this reason code was found on the EOB or with the submitted documentation.
   - 88053 – no explanation of this reason code was found on the EOB or with the submitted documentation.

- 01115 – no explanation of this reason code was found on the EOB or with the submitted documentation.

2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

4. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." Review of the *Table of Disputed Services* finds that the requestor has not properly listed the amounts billed, amounts paid and amounts in dispute in the appropriate columns required by Division instructions. The Division notes that the requestor has listed an amount of $15,841.53 as the amount billed for every disputed service, but a total amount billed of $10,981.07. Additionally, the requestor has listed $900.00 as the amount paid for every disputed service, but a total amount paid of $900.00. The Division further notes that the requestor has listed the amount in dispute for each service as $10,981.07, but indicates the total amount in dispute is also $10,981.07. Moreover, the requestor has listed the disputed date of service as 04/12/05 for all services, however the submitted documentation does not support that all the services in dispute were performed on date of service 4/12/2005. Review of the submitted medical bill finds that some of the disputed services (including services billed under revenue codes 250, 251, 255, 258, 259, 260, 270, 272, 320, 360, 370, 410, 450, 621, 710, 761, and 762) were performed on service date 4/13/2005. The Division therefore concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(1)(C).

5. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).

6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "a fair and reasonable reimbursement is 75 percent of the billed charges."
   - The requestor did not submit documentation to support that a fair and reasonable reimbursement is 75 percent of the billed charges.
   - The requestor did not discuss or explain how payment of 75 percent of the billed charges would result in a fair and reasonable reimbursement.
   - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(e)(2)(C), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

**DECISION:**

| | | |
|---|---|---|
| | **Grayson Richardson** | **5/28/2010** |
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |
| | | **5/28/2010** |
| Authorized Signature | Medical Fee Dispute Resolution Manager | Date |

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**